DOCUMENT RESUME

ED 166 589 CG 013 197

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TITLE Mental Health in the Schools: Parent Training.
PUB DATE Aug 78
NOTE 20p.; Paper presented at the Annual Convention of the American Psychological Association (Toronto, Ontario, CANADA, August, 1978)

EDRS PRICE MF-$0.83 HC-$1.67 Plus Postage.
DESCRIPTORS *Behavior Problems; Junior High Schools; Junior High School Students; Mental Health; Parent Child Relationship; *Parent Counseling; *Parent Education; *Parent Teacher Cooperation; *Student Behavior; *Teacher Role

ABSTRACT

A training program by teachers for parents of school children who were creating problems at school was investigated. Parents (N=10 couples) rated their child's at-home behavior by means of a checklist, participated in group sessions led by the teachers with a focus on means for dealing with student behavioral problems, and then rated their child's at-home behavior after the completion of the group sessions. The control group of six parental couples completed only the behavior checklists at the beginning and end of the final grading period of the school year. A correlated T-test between parental ratings before and after group involvement indicated significant subjective positive changes by the parents, while no significant changes occurred among the control group. Additionally, teachers rated children whose parents attended the group sessions more positively in overall classroom behaviors whereas control group children's ratings were unchanged. (Author/BLM)

Mental Health in the Schools: Parent Training

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This paper was presented as part of the Symposium entitled "Pediatric Psychology: School as a Mental Health Provider", at the annual convention of the American Psychological Association, Toronto, Canada, August, 1978.

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ABSTRACT

The public school could take a more active role in the mental health of the families it serves. A rationale and background are provided for this thesis as well as pilot data on one economical method of implementation. It was found that teachers training parents can affect change in their children who were creating school problems.

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For those of us working in pediatric settings, the complaint of "school problems" is common. Sometimes the phrase accompanies a referral standing by itself but more often along with other diagnostic labels such as hyperactivity, encephalitis, or adjustment reaction of childhood. Parents' concerns usually include disruptive school behavior or poor scholastic achievement and they and personnel from the school are usually interested in how to proceed. In addition to information about the behavioral aspects associated with the medical diagnosis, recommendations are often given to teachers such as increased structure in the classroom (perhaps through a contracting system), a particular set of curriculum materials, or a special class placement. However, teachers who often give extensive and high-quality efforts in the classroom discouragingly admit that they sometimes make limited progress since changes in the classroom approach are only part of the solution. Sometimes the missing component is some home or family change which would either improve the overall emotional climate and/or supplement the teacher's efforts.

Therefore, to help improve the home situation, a referral is sometimes made to a counseling agency, but there are a number of problems with such a referral. First, parents are often reluctant to seek mental health services because of the usual stigma associated with trying to obtain this type of help. Sometimes financial strain contributes to the hesitancy. Then, too, gaining sufficient inertia to find a new place and make new personal contacts defeats follow-through.

Apart from follow-through, even if the family does find its way to a counseling agency, not every agency has staff who can adequately understand, coordinate and/or integrate medical, school and family concerns around a child. For example, a youngster recently seen with Familial Dysautonomia, presented numerous

physical conditions necessitating a number of school concessions. A more common referral has been the mainstreamed spina bifida youngster about whom school personnel and parents wonder whether the child might be using urinary or ambulatory difficulties as a tool to avoid certain school rules, activities or academic demands. However, sorting through and deciding which are realistic demands for these kinds of children would be difficult for a counselor outside a medical environment. Therefore, for whatever reason, school problems which may have some etiological basis in the home and hospital seldom get addressed appropriately. Even so, if all children who were experiencing behavioral difficulties in the school because of a medical condition and/or home atmosphere were referred and went to mental health centers, present counseling resources would be overwhelmed.

A solution to these referral problems would be some type of quality counseling program offered by the local school. There, the mental health stigma would be minimized since counseling could be presented as another school service. A minimal, if any, charge need be requested since basic overhead expenses have already been paid. School is a familiar setting for the uneasy parent. Therefore, it seems sensible to arrange the coordination of educational and therapeutic services within the local school.

Take for example, a school-age child diagnosed as "hyperactive". Such a child might be tried on Ritalin, but as a number of studies seem to indicate, though school behavior improvement is probable, home behavior is not often effected (Wolraich, 1977; O'Leary and Pelham, 1978). In addition, seldom are there any real academic improvements despite the increased attentional skill or decreased activity level effected by the medication. Perhaps better would be a 2-pronged approach: (1) a trial on medication, objectively monitored by know-

ledgeable and uninvolved school people in communication with the appropriate teachers and physicians, and (2) a parent or family counseling program which would focus on basic child management and communication skills, thereby enlisting parental help, hopefully improving home relationships and making consistent those procedures used in the home and at school.

The medical aspects of this particular example are easily accomplished if the involved school person knows about hyperactivity, knows how to use a valid rating scale, and can coordinate parent, physician and a monitoring system. School consultation by a pediatric psychologist has already been discussed by Dr. Schroeder and it is this unique working relationship with school, hospital and family that often proves so valuable. Here, the role of the pediatric psychologist is informational concerning the particular medical-behavioral difficulty as well as programmatic. That is, using available capabilities deciding how best to deal with and ameliorate the problem in the school. Improvement at home, the second part of the 2-pronged approach is less straightforward.

Working informationally with the parents or the entire family around a particular medical and/or school problem is as important and needed as teacher education. The pediatric psychologist should be able to rely on the school personnel here if he/she has done a good job of making clear the medical condition and its behavioral implications to these personnel. However, helping parents get involved and make behavioral changes is something else. Neither pediatric nor school psychologists, nor other school people such as guidance counselors or teachers could deal individually with the number of families whose children are creating school problems. Therefore, a group approach to family change would seem a likely alternative, especially since many of the problems and goals of participants would be similar.

The concept of group parent training is not new. The first reference to this topic that I could find was published in the early 1800's when such groups were called "maternal associations" (Croake and Glover, 1977). Over the years the content of parent groups has varied, focusing on such things as child development norms, information about specific areas of child development such as personality and rearing techniques (including discipling methods), and interpersonal communication. Such groups varied in the influence exerted by the leader, and in turn their formats have ranged from highly didactic training to relatively unstructured "leaderless" opinion sharing.

A number of approaches are currently popular including PET (Gordon, 1970), the Dreikers approach (Dreikers & Soltz, 1963), and behavior modification (Krumboltz & Krumboltz, 1972). However, disappointingly with some exceptions, little good research is available to document the effectiveness of these approaches in terms of affecting children's or their parents' behaviors. Most studies that have been reported are sketchy regarding the procedures used, or the program's format, and were poorly designed with respect to how effectivenss was measured, with most omitting an appropriate comparison or control group.

One exception to some of these methodological criticisms has been group parenting research associated with a behavioral approach. As O'Dell (1974) who reviewed this area so well has concluded, training parents in behavioral techniques (more than general principles) is effective in changing parental attitudes toward children as well as home behaviors of those children. Fewer convincing data exist on maintenance of the desired behavior or whether parents themselves change behavior patterns. Nevertheless, it seems that professionals can teach parents skills which they in turn can employ in making changes in the behaviors of their children.

However, lets return to the theme begun earlier to this paper, namely how can the pediatric psychologist help resolve behavior and adjustment difficulties in the school? The group approach would seem to hold promise. Torigoe (1977) has reported some preliminary data which suggest that the parent group format can effect school performance by generalizing from home to school for both targeted and non-targeted home behaviors. Teachers' subjective ratings were more positive for only the experimental (counseled) group and academic gains were greater only for that group as well. Unfortunately, psychologists, especially those affiliated with health care delivery systems, can not offer their service to many of the parents whose children are having home and related school problems. Consequently, one wonders whether the school itself might not take a more aggressive approach in this area. In discussing this notion with local school people, a common response has been either we don't have people with that kind of training, or such people just don't have the time. As common are important unexpressed reservations such as doubts concerning the effectiveness and desirability of this type of program.

Nevertheless a number of school districts are exploring the potential value of having some type of counseling program available through the school. The purpose of such a program would be twofold. First, the district (perhaps in conjunction with the local Department of Mental or Public Health) would offer parent groups with a preventive emphasis, working with interested parents whose children fall within prescribed age groups. For example, during one month of the year, four-year-olds might be the topic of discussion whereas five- and six-year olds might be the focus the next month and young adolescents the next, etc. Developmental norms, educational possibilities in the home as well as problem-solving approaches could be highlighted. In addition, district-wide speciality groups might meet to discuss such topics as hyperactivity, learning disabilities, mental retardation, or cerebral palsy and their relevency to the school. The pediatric psychologist could serve as consultant and/or model for such efforts.

The second focus of a "family services" department within the school would be crises oriented to deal with families of those children who are creating school behavioral problems, when it is thought the family could have some type of ameliorating influence. Of course, medically related adjustment problems would also deserve this type of intervention, being useful with spinal cord injury, endocrine and orthopedic disorders, to name but a few school re-entry problem conditions. In this way, rather than assuming a parent surrogate role, the school would form an alliance with the parents providing information, guidance, as well as a forum for focusing upon behavioral and adjustment difficulties. A mutually acceptable strategy could be determined and a consistent program of intervention could be begun at home and at the school. The teacher and parent would have a readily available consultant to deal with coordinating efforts as well as generating problem solutions.

An issue often raised is how can a school provide this type of service without hiring a number of expensive professionals, many of whom are unfamiliar with school procedures and problems. One answer we have found quite promising is to work with already existing staff, i.e., teachers and psychologists, whose district has released them from some teaching and testing responsibilities, and who have expressed interest in learning those skills that might prove helpful in working with families. I've seen this approach tried with children both at the elementary school and junior high school level and the results have been encouraging. I would like to briefly describe our pilot program though it should be realized that it still is being modified in order to meet a number of unanticipated demands as well as opportunities.

About two years ago, one of the local school districts in Wilmington decided to explore the value of a family counseling program under the aegis of the school

district. Two teachers were given part-time release from their teaching duties in order to both acquire basic skills in leading a parents' group in one junior high school. These teachers first observed a parent group I conducted and then proceeded to teach a parent group on their own in the school with supervision. Following each of their group sessions, the teachers (one male and one female) would discuss the session with me and we would listen to selected portions of an audiotape of the session. In addition, we would review the teaching content of the next session and often we would role play the session using frequently asked questions which I would pose. Here are some of the details which characterized our particular brand of parent group.

A letter was sent out to the families of the children teachers designated as experiencing behavioral difficulties in school. The letter described the purpose and format of the group, what would be expected of them as group participants, the dates the sessions would be held, the fact that sessions would be taped, the "rules" governing the sessions, and a contact person who should be called if the parents were interested in attending. Upon contacting the school, the parents were sent a contract which enumerated responsibilities of both the group leaders as well as the parent participant. One of these responsibilities included a deposit which would be refunded to the parents for attendance and assignment completion for each session. In addition, the contract also included a "Behavioral Definitions Form" which requested the parents describe two behaviors they would like their child to either increase or decrease. This allowed us to focus on well thought-out problems of immediate concern to these parents even during the first session. It also allowed us to request parents to start counting behaviors relevant to the parents the very first week.

The parent group curriculum is listed in Table 1 of the handout and you can see it follows a fairly standard behavioral approach. Because most of the children in this instance were young adolescents, greater emphasis was given to contracting skills than might normally occur when younger children would be the focus. Six sessions were held and each session was an hour and a half in length. During the second session Gerald Patterson's (1976) book Families was loaned out and assignments from this book were made throughout the remainder of the sessions. This particular book was chosen because its writing style seemed appropriate for the middle class family who tended to enroll in these sessions. In addition, many more of the examples used in Families referred to older children or adolescents.

In order to assess the worth of this entire effort, the following pilot project was conducted. Perhaps at the outset it would be well to remark that a particular approach is not being evaluated here, but rather it was investigated whether teachers could produce positive changes in students' behaviors at school and/or home, using a parent training approach.

Subjects. Thirty-five initial letters were sent and sixteen families responded. Ten families were chosen to take part in the group and served as the experimental group. The randomly selected families were told that the present group could not accommodate them, but that we would like their help in the future and they would be accepted to a subsequent group if they still desired that type of assistance. This group comprised the control group. The ages of the children of these families ranged from thirteen to fifteen with six females and four males. It is interesting to note that parents with male experiencing difficulty in school were more likely to respond than were those with the target children, even though a larger number of males as initially referred.

Materials and Procedure. To assess a parent group effect, a pre-post checklist was used for parents and teachers. During the initial mailing and last session, the behavior rating scale (see Table 2) was given to each parent who in turn made subjective judgments about their child's "typical" behavior at home. Parents were not told that they would again be asked to fill out the questionnaire during the last session. Control group parents were sent a mailing at comparable times, but of course, received no formal instruction in management techniques. At the conclusion of the sessions (which corresponded to the end of the school year) grades for each child were obtained for both the final marking period and the marking period preceding the beginning of the group (which coincided with the beginning of the sessions).

In addition, the 10 item Conners's Teacher Rating Scale was given to the teachers both prior to and at the conclusion of the sessions. They were asked to rate both experimental and control students at these 2 times, [illegible] of course, the teachers were [illegible] which students' parents were attending the group.

Results. A [illegible] between parental ratings before and after group involvement [illegible] changes [illegible] positively perceived by the parents ([illegible]) [illegible] were obtained with the control group analysis. For neither group were there grade changes between the fifth and sixth marking sessions. There was a tendency for the experimental group to have fewer absences or illnesses, but this trend was not statistically significant. However, there were fewer referrals to school officials [illegible] of the experimental group ($\chi^2 = 4.05$, p [illegible] .05).

Teacher ratings were analyzed and were found consistent with the results of the parent ratings. That is, children whose parents attended the group

sessions were rated more positively in overall classroom behaviors, whereas control group children's ratings were unchanged.

These data would suggest that parents felt that the interaction between them and their children had improved as a result of nine hours of formal group involvement. No academic gains were apparent, but then behavior change probably was not beginning to occur at home until at least halfway through the last marking period and therefore reversing the academic trend at that point might have been quite difficult. In addition, specific academic skills were not addressed per se (except for completing homework in some classes) but rather most parents focused on specific behaviors which usually were not directly school related. Examples of these would be such things as stealing, keeping a room clean, being in at an agreed upon hour, and various household chores. Therefore, it would seem reasonable that academic changes would not be immediately evident with those types of behaviors being targeted. Getting along better with adult authority figures at home was presumedly achieved, and perhaps was seen at school in the lower number of misbehavior referrals made to school officials.

It can not be argued from these data that the training these teachers received was instrumental in the change which was produced. Nothing here even argues for the necessity of training at all. However, the teachers themselves thought they needed it and, as the unbiased trainer of these teachers, I too felt that they acquired a number of valuable group leadership skills as well as learned some effective techniques for dealing with a number of behavior problems often associated with this age group! It is an empirical question of course, whether training is helpful and if so, which kind of training is the best match for a given trainee style or referral problem area.

Perhaps, as important as the objective data are some of the subjective changes which were noted by the teachers of some of the experimental group subjects. In a few instances teachers approached the parent group trainers

inquiring what was being taught and mentioned that a student's work habits and/or class demeanor had noticeably changed. Apparently because of noticeable changes in their parents' behavior, some of the experimental group students (and in some cases their siblings) asked parents what they were learning and requested to attend a group session which they did during a pizza party at an additional session.

It should be noted that at the end of the group sessions all parents were told that if other parenting, marital or personal counseling services were desired to continue to improve things, the group leaders should be told and the parent(s) would be helped to obtain those services in available community agencies. No parents initiated this type of contact though in some instances it seemed appropriate. A more direct suggestion to these parents did not result in any known referral requests for further assistance. Since in each case, prior suggestions for professional help were not followed, it is felt that this hesitancy was not engendered by the group experience. Rather, it is of interest that these hesitant parents availed themselves of this school sponsored program.

The pilot data reported earlier would suggest then that involvement in a teacher-led parents' group can effect changes in parental and teacher attitudes toward their children who had presented as behavior and/or academic problems children at school.

Based upon these findings, it is a matter of some debate as to whether school involvement of this type is appropriate since no significant academic gains were forthcoming. Those holding a more traditional view may very well argue the school has little business performing parent training or family therapy. Rather it is the school's responsibility to help students learn a basic corpus of material. On the other hand, others would argue that such compartmentalization is very myopic since the areas of academic achievement and personal and home life atmosphere certainly interact. It may be that academic effects will be

obtained as these students experience an improved home milieu for a longer period.

I think these data do support continuing efforts along this line in order to clarify whether academic gains can be realized with this approach. There are many other research areas which need to be examined more closely and include such things as the importance of many kinds of training, teacher trainee characteristics, the problems best treated by a group approach, and areas affected other than school grades, such as self-image, peer relationships and delinquency. On an intuitive level, it would seem that the latter areas have rich dividends to pay if pursued. This approach would also get mental health people working with educators and the hybrid product might be greater than the sum of its parts. Given the fact that a pilot program has had value, the potential for using an expanded approach as a way of generally increasing the quality of life for families is exciting.

Until now, attention has been given to training teachers to lead parent groups. Another approach would be to encourage and, if necessary, help train school psychologists to both lead such groups as well as train teachers in their districts to become so involved since, it seems unlikely that school psychologists would be able to lead the number of parent groups necessary. The role of the school psychologist varies greatly from district to district but in many is that of a portable, perpetual I.Q. generating device about which teachers and administrators have little understanding. Consequently, it would seem appropriate for the school psychologist to exercise leadership in the formation and evaluation of mental health programs in the school.

Perhaps it should be stated that any parent group program (or any other) initiated in a school should have built into it some type of monitoring system which will allow evaluation of both the overall program as well as individual group leaders. Some people make groups work and others don't. We need to know how to discriminate between these types of people so as to make the programs

effective as well as model the "keep you honest" procedure advocated by those of a behavioral persuasion.

How does a pediatric psychologist fit into all this? As has already been noted, the pediatric psychologist often already has input to teachers and various school psychologists and administrators. As an objective, non-school, a-political professional, his/her influence could foster careful thinking about the role of mental health in the school, and better insure appropriate implementation if a plan were accepted. Of course, the pediatric psychologist would contribute his medical-psychological expertise as consultant to school and family so that appropriate behavior remediation programs would be designed in the group or classroom. Having parent training groups as an available option for medically related school problems as well as more traditional learning disability and behavioral difficulties would make less wide the gulf between clinic diagnosis and school or home improvement.

In this paper I have described a possible mechanism to help improve the quality of mental health for students, both at home and in the school. To do this, I have advocated the inclusion of a school based "family services" department which would offer at least parenting instruction. Because of budgetary restraints, people being hired exclusively for the delivery of this service seems unlikely, but it does appear possible to train existing staff to provide this service and pediatric psychologists are in a unique position to be germinal in this effort. In terms of priorities, it seems proper that the institution which demonstrated innovative leadership offering driver's education, tennis lessons, and job training, should now show similar leadership in assisting their graduates in the more important learning activity of parenting.

REFERENCES

Croake, J. and Glover, K.E. A history and evaluation of parent education. The Family Coordinator, 1977, 26, 151-158.

Dreikers, R. & Soltz, V. Children the challenge. N.Y.: Meredith, 1964.

Gordon, T. Parent-effectiveness training: The "no-lose" program for raising responsible children. New York: Wyden, 1970.

Krumboltz, J.D. and Krumboltz, H.B. Changing children's behavior. Englewood Cliffs, N.J.; 1972.

O'Dell, S. Training parents in behavior modification: A review. Psychological Bulletin, 1974, 81, 418-433.

O'Leary, S. and Pelham, W.E. Behavior therapy and withdrawal of stimulant medication in hyperactive children. Pediatrics, 1978, 61, 211-217.

Patterson, G.R. Families: Applications of social learning to family life. Champaign, IL: Research Press, 1975.

Porigoe, R.Y. Effecting behavioral affective, and cognitive changes in children through the involvement and training of significant others: A low cost program in collaboration with the school. Catalog of Selected Documents in Psychology, 1977, 7, 18.

Wolraich, M.L. Stimulant drug therapy in hyperactive children: Research and clinical implications. Pediatrics, 1977, 60, 512-518.

Table 1

1st Week	Introduction: Parent Group Curriculum Why We Do The Things We Do (including developmental norms) Steps 1 and 2: What's the Problem and How Big a Problem is it? (Defining and Counting Behavior)
2nd Week	Changing the Things We Do: Reward Principles Step 3: Designing an Intervention Plan
3rd Week	More Change: Charts and Point Systems
4th Week	When Enough Is Enough: Punishment Principles
5th Week	More Change: Contracting
6th Week	No Session
7th Week	Taking Stock: Behaviors and Feelings Step 4: Evaluate and Troubleshoot

TABLE 2

PARENT CHECKLIST OF BEHAVIOR

Name of teenager _____ Age _____

Date _____

BEHAVIOR	Not at all	Sometimes	Moderately	Quite a bit	Very much
1. Can't sit still or fidgets					
2. Talks back to adults					
3. Won't watch TV for long					
4. Watches TV too long					
5. Bullies others					
6. Refuses to obey parents at home					
7. Feelings easily hurt					
8. Fights					
9. Fearful					
10. Seeks help for things he can do alone					
11. Talks excessively					
12. Excessive use of phone					
13. Lack close friends					
14. Unaffectionate					
15. Lies					
16. Fails to finish projects begun					
17. Steals					
18. Fails to return home on time					
19. Disruptive in class					
20. Lets himself get pushed around					
21. Excitable, impulsive					
22. Constantly changing activities					
23. Destructive to property					
24. Demanding					
25. Trouble with police					
26. Truancy					
27. Pouting and sulking					
28. Belligerant to adults					
29. Inattentive					
30. Has last say					
31. Other					